APPENDIX C

NURSING FACILITY AND HOSPITAL LEVEL OF CARE CRITERIA

NURSING FACILITY CARE CRITERIA UNDER MEDICAID

Nursing facility care is the provision of services for persons whose health needs require medical and nursing supervision or care. These services can be provided in various settings, institutional, and noninstitutional. Both the functional capacity and nursing needs of the individual must be considered in determining the appropriateness of nursing facility care.

Individuals may be considered appropriate for nursing facility care when one of the following describes their functional capacity:

A. Rated dependent in two to four of the Activities of Daily Living (Items 1-7), and also rated semi-dependent or dependent in Behavior Pattern and Orientation (Items 8 and 9), and semi-dependent in Medication Administration (Item 11).

B. Rated dependent in two to four of the Activities of Daily Living (Items 1-7), and also rated semi-dependent or dependent in Behavior Pattern and Orientation (Items 8 and 9), and semi-dependent in Joint Motion (Item 12).

C. Rated dependent in five to seven of the Activities of Daily Living (Items 1-7), and also rated dependent in Mobility (Item 10).

D. Rated semi-dependent in two to seven of the Activities of Daily Living (Items 1-7), and also rated dependent in Mobility (Item 10), and Behavior Pattern and Orientation (Items 8 and 9). An individual in this category will not be appropriate for intermediate care unless he/she also has a medical condition requiring treatment or observation by a nurse.

Even when the one of the above criteria is met, placement in a non-institutional setting should be considered before nursing home placement is sought.

FUNCTIONAL STATUS

The following abbreviations are used:

I = independent, d = semi-dependent, D = dependent, MH = mechanical help, HH = human help.

1. Bathing

   a. Without help (I)
   b. MH only (d)
   c. HH only (D)
   d. MH and HH (D)
   e. Is bathed (D)

2. Dressing

   a. Without help (I)
   b. MH only (d)
   c. HH only (D)
   d. MH and HH (D)
   e. Is dressed (D)
   f. Is not dressed (D)

3. Toileting

   a. Without help day and night (I)
   b. MH only (d)
   c. HH only (D)
   d. MH and HH (D)
   e. Does not use toilet room (D)

4. Transferring

   a. Without help (I)
   b. MH only (d)
   c. HH only (D)
   d. MH and HH (D)
   e. Is transferred (D)
   f. Is not transferred (D)

5. Bowel Function

   a. Continent (I)
   b. Incontinent less than weekly (d)
   c. Ostomy - self care (d)
   d. Incontinent weekly or more (D)
   e. Ostomy - not self care (D)

6. Bladder Function

   a. Continent (I)
   b. Incontinent less than weekly (d)
   c. External device - self care (d)
   d. Indwelling catheter - self care (d)
   e. Ostomy - self care (d)
   f. Incontinent weekly or more (D)
   g. External device - not self care (D)
   h. Indwelling catheter - not self care (D)
   i. Ostomy - not self care (D)

7. Eating/Feeding

   a. Without help (I)
   b. MH only (d)
   c. HH only (D)
   d. MH and HH (D)
   e. Spoon fed (D)
   f. Syringe or tube fed (D)
   g. Fed by IV or clysis (D)

8. Behavior Pattern and Orientation

a. Appropriate or Wandering/ Passive less than weekly	+	Oriented	(I)
b. Appropriate or Wandering/ Passive less than weekly	+	Disoriented Some Spheres	(I)
c. Wandering/Passive Weekly or more	+	Oriented	(I)
d. Appropriate or Wandering/ Passive less than weekly	+	Disoriented All Spheres	(d)
e. Wandering/Passive Weekly or more	+	Disoriented Some or All Spheres	(d)
f. Abusive/Aggressive/Disruptive less than weekly	+	Oriented or Disoriented	(d)
g. Abusive/Aggressive/Disruptive weekly or more	+	Oriented	(d)
h. Abusive/Aggressive/Disruptive weekly or more	+	Disoriented	(D)

9. Mobility

   a. Goes outside without help (I)
   b. Goes outside MH only (d)
   c. Goes outside HH only (D)
   d. Goes outside MH and HH (D)
   e. Confined - moves about (D)
   f. Confined - does not move about (D)

10. Medication Administration

    a. No medications (I)
    b. Self-administered - monitored less than weekly (I)
    c. By lay persons, monitored less than weekly (I)
    d. By Licensed/Professional nurse and/or monitored weekly or more (d)
    e. Some or all by professional nurse (D)

11. Joint Motion

    a. Within normal limits (I)
    b. Limited motion (d)
    c. Instability - corrected (I)
    d. Instability - uncorrected (D)
    e. Immobility (D)

NURSING NEEDS

The following are examples of services provided or supervised by licensed nursing and professional personnel; however, no single service necessarily indicates a need for nursing facility care:

1. Application of aseptic dressings.

2. Routine catheter care.

3. Inhalation therapy after the regimen has been established.

4. Supervision for adequate nutrition and hydration for individuals who, due to physical or mental impairments, are subject to malnourishment or dehydration.

5. Routine care in connection with plaster casts, braces, or similar devices.

6. Physical, occupational, speech, or other therapy.

7. Therapies, exercise and positioning to maintain or strengthen muscle tone, to prevent contractures, decubiti, and deterioration.

8. Routine care of colostomy or ileostomy.

9. Use of restraints including bedrails, soft binders, and wheelchair supports.

10. Routine skin care to prevent decubiti.

11. Care of small uncomplicated decubiti, and local skin rashes.

12. Observation of those with sensory, metabolic, and circulatory impairment for potential medical complications.

The final determination for nursing facility care will be based on the individual's need for medical and nursing management. Nursing facility care criteria are intended only as guidelines. Professional judgment must always be used to assure appropriateness of care.

SPECIFIC SERVICES WHICH DO NOT MEET THE CRITERIA FOR NURSING FACILITY CARE

A. Care needs that do not meet the criteria for nursing facility care include, but are not limited to, the following:

1. Minimal assistance with activities of daily living.

2. Independent use of mechanical devices such as a wheelchair, walker, crutch, or cane.

3. Limited diets such as mechanically altered, low salt, low residue, diabetic, reducing, and other restrictive diets.

4. Medications that can be independently self-administered or administered by the individual with minimal supervision.

5. The protection of the individual to prevent him from obtaining alcohol or drugs, or from confronting an unpleasant situation.

6. Minimal observation or assistance by staff for confusion, memory impairment, or poor judgment.

B. Special attention should be given to individuals who receive psychiatric treatment. The need for nursing facility care is usually questionable when the primary diagnosis or the primary needs are psychiatric. These individuals must have been screened to determine the need for active treatment for a condition of mental illness and determined to have primary care needs that meet the criteria for nursing facility care.

SUMMARY

The final determination of an individual's care is a professional decision based on total individual needs. Individuals present an infinite variety of care needs, making it virtually impossible to establish a review system that will eliminate the need for professional judgment within the confines of program criteria.

In conclusion, when involved in individual placement, all available resources must be explored, i.e., the immediate family, other relatives, home health services, and other community resources. When applying the criteria, primary consideration is to be given to the utilization of available community/family resources.

Any individual who meets the Medicare skilled criteria and is also Medicaid eligible must be admitted to a facility which has Medicare skilled beds. It is the responsibility of the nursing facility to ensure that an individual who meets the Medicare skilled care criteria is admitted only if the facility is certified for Medicare participation. Medicaid will not reimburse a nursing facility for a resident who meets Medicare skilled care criteria, but who is not placed in an appropriate Medicare-certified bed.

INPATIENT HOSPITAL CARE CRITERIA UNDER MEDICAID

Inpatient hospital care is the provision of services for persons whose severity of illness and intensity of service need require admission to a hospital for bed occupancy for medical and nursing care. An individual can be admitted to a hospital as an inpatient only if inpatient care is reasonable and medically necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. The service must be consistent with the diagnosis or treatment of the patient's condition and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient services do not include:

- Social behavior modification
- Remedial education
- Day care
- Psychological testing done for the purpose of educational diagnosis, school or institution admission, and/or placement or upon court order
- Alcoholism and drug abuse therapy
- Socialization
- Play Therapy
- Occupational Therapy

The physician is responsible for determining whether the individual is appropriate for admission to a hospital based upon:

- The individual's severity of illness, measured by the individual's vital signs, laboratory, radiology and other tests, functional impairment and physical findings.
- The intensity of the individual's service needs: monitoring and supervision of care needs, medications and treatments needed, and procedures requiring specialized care.

The measures of severity of illness and intensity of care needs will vary according to the individual's diagnosis and system affected. The physician is ultimately responsible for determining whether the individual requires hospitalization. Federal regulation (42 CFR 456.60) requires that a physician certify in writing that inpatient hospital services are necessary for each hospitalized recipient at the time of admission. Federal regulations also require that a physician certify in writing that inpatient hospital services would be necessary for any individual seeking admission to a Home and Community Based Care waiver program as an alternative to hospitalization.

This certification of the need for inpatient hospital care in the absence of a Home and Community-Based Care waiver alternative must be accompanied by a complete medical, functional and social assessment and plan of care which clearly substantiates the physician's decision and documents that the individual meets the criteria for Home and Community Based Care waiver services. This assessment and plan of care are documented on the DMAS-95 and DMAS 113B as discussed in Chapter IV.

DMAS utilization review staff will review this documentation prior to payment of any claims for Home and Community-Based Care services offered in lieu of hospitalization. Periodic re-evaluations of the individual's medical and functional status will be completed by DMAS staff and by case management/care coordinator staff to ensure that the inpatient hospital care criteria continue to be met.